



*Homeless Solutions Policy Board
Chairpersons*

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The Front Door Assessment Tool and Referral Decision Worksheet were developed for use in Dayton and Montgomery County. The questions and scoring are specific to the providers, resources and client needs in Dayton and Montgomery County. These materials should be reviewed and revised before implementation in another community.

For more information please contact Joyce Probst MacAlpine, Manager Housing and Homeless Solutions, Montgomery County at 937-225-4218 or macalpinej@mcohio.org.

Montgomery County Front Door Intake

Last Name of Head of Household:	First Name:	Middle Initial	Today's Date:
DOB:	Age:	SSN:	

Describe the circumstances that led you to come here today:

What do you need right now?

What is your plan for leaving the shelter? _____

HOUSEHOLD TYPE

☐ Single Adult
 ☐ Female Single Parent
 ☐ Male Single Parent
 ☐ Two Parent Family
 ☐ Foster Parent
☐ Two or More Adults with no children <18
 ☐ Grandparent and Child
 ☐ Non-custodial care giver
 ☐ Other: _____
 Number in Household: No. of Adults _____ No. of Children _____
 Marital Status of Head of Household: married ☐ separated ☐ divorced ☐ single ☐

HOUSEHOLD INFORMATION

List information about the people in your current household. Please start with the Head of Household (HOH):

First Name	Last Name	Gender	DOB	SSN	Relationship to HOH*	Custody if Child <18, Y or N	Veteran Y or N	Race	Ethnicity **	Disabled (Y or N)
1. Head of Household										
2.										
3.										
4.										
5.										

*Relationship to Head of Household: choose: self, spouse, partner, son, daughter, mother, father, sister, brother, grandparent

** Ethnicity: enter Hispanic/Latino [H/L] or Non Hispanic/Latino [NHL]

Phone/Email for Household: (Repeat as necessary)

Name: _____ Phone Number: _____ Email: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship:

Street Address: _____ City, State, Zip: _____

Montgomery County Front Door Intake

HOUSING ARRANGEMENTS: WHERE DID YOU STAY THE LAST NIGHT (before shelter)?

Street Address:	City	State	Zip
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Facility or Program Name (if Applicable)	Monthly Cost to Live There: \$ _____
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How long were you staying there? (Choose one)

☐ One week or less ☐ More than one week, but less than one month ☐ One to three months
☐ More than three months, but less than one year ☐ One year or longer ☐ Don't Know

Type of Housing/Accommodation: (Choose one)

<input type="checkbox"/> Rental by client, no housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with other (non-VASH) housing subsidy <input type="checkbox"/> Owned by client, no housing subsidy <input type="checkbox"/> Owned by client, with housing subsidy <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friends room, apartment or house <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Permanent housing for formerly homeless persons (such as SHP, S+C, SRO)	<input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Hotel or motel paid without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Safe Haven <input type="checkbox"/> Psychiatric Facility <input type="checkbox"/> Substance Abuse treatment facility or detox center <input type="checkbox"/> Hospital <input type="checkbox"/> Jail, prison, juvenile detention facility <input type="checkbox"/> Place not meant for habitation (e.g. a car, abandoned bldg, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Don't know <input type="checkbox"/> Other
--	--

Type of Housing Subsidy (if applicable): ☐ HAP ☐ DMHA ☐ ESPG ☐ Section 8 ☐ S+C ☐ SHP
☐ VA Supportive Housing (VASH) ☐ None ☐ Other: _____

What is the PRIMARY reason you left this housing? (Choose One)

☐ Eviction ☐ Unable to pay rent ☐ Utility shut off ☐ Domestic Violence
☐ Unsafe situation ☐ Fire ☐ Condemned property ☐ Foreclosure (renter)
☐ Foreclosure (owner) ☐ Overcrowded ☐ Conflict with others ☐ Moved from out of town
☐ Discharge from program ☐ Physical illness ☐ Discharge from hospital ☐ Jail or Prison release
☐ Substance Use ☐ Mental Illness ☐ Other (please describe): _____

If you are being evicted, do you have a court date? ☐ Yes ☐ No Date you need to leave: month/day

If you were staying with family or friends, could you safely stay there if we offered you some help? ☐ Yes ☐ No

If yes, explain: _____

Conditions under which you could return to the place you stayed last night:

LAST PERMANENT RESIDENCE (if different from where you stayed last night)

Street Address:	City	State	Zip
-----------------	------	-------	-----

Facility or Program Name (if Applicable)	Monthly Cost to Live There: \$ _____
--	---

How long were you staying there? (Choose one)

☐ One week or less ☐ More than one week, but less than one month ☐ One to three months
☐ More than three months, but less than one year ☐ One year or longer ☐ Don't Know

Montgomery County Front Door Intake

Type of Housing/Accommodation: (Choose one)

- | | |
|--|--|
| <input type="checkbox"/> Rental by client, no housing subsidy
<input type="checkbox"/> Rental by client, with VASH housing subsidy
<input type="checkbox"/> Rental by client, with other (non-VASH) housing subsidy
<input type="checkbox"/> Owned by client, no housing subsidy
<input type="checkbox"/> Owned by client, with housing subsidy
<input type="checkbox"/> Staying or living in a family member's room, apartment or house
<input type="checkbox"/> Staying or living in a friends room, apartment or house
<input type="checkbox"/> Foster care home or foster care group home
<input type="checkbox"/> Permanent housing for formerly homeless persons (such as SHP, S+C, SRO) | <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher
<input type="checkbox"/> Hotel or motel paid without emergency shelter voucher
<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/> Safe Haven
<input type="checkbox"/> Psychiatric Facility
<input type="checkbox"/> Substance Abuse treatment facility or detox center
<input type="checkbox"/> Hospital
<input type="checkbox"/> Jail, prison, juvenile detention facility
<input type="checkbox"/> Place not meant for habitation (e.g. a car, abandoned bldg, bus/train/subway station/airport or anywhere outside)
<input type="checkbox"/> Don't know
<input type="checkbox"/> Other |
|--|--|

Type of Housing Subsidy (if applicable): ☐ HAP ☐ DMHA ☐ ESPG ☐ Section 8 ☐ S+C ☐ SHP
☐ VA Supportive Housing (VASH) ☐ None ☐ Other: _____

What is the PRIMARY reason you left this housing? (Choose one)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Evicted | <input type="checkbox"/> Unable to pay rent | <input type="checkbox"/> Utility shut off | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Unsafe situation | <input type="checkbox"/> Fire | <input type="checkbox"/> Condemned property | <input type="checkbox"/> Foreclosure (renter) |
| <input type="checkbox"/> Foreclosure (owner) | <input type="checkbox"/> Overcrowded | <input type="checkbox"/> Conflict with others | <input type="checkbox"/> Moved from out of town |
| <input type="checkbox"/> Discharge from program | <input type="checkbox"/> Physical illness | <input type="checkbox"/> Discharge from hospital | <input type="checkbox"/> Jail or Prison release |
| <input type="checkbox"/> Substance Use | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other (please describe): _____ | |

If you were staying with family or friends, could you safely stay there if we offered you some help? ☐ Yes ☐ No

If yes, explain: _____

Conditions under which you could return:

HOUSEHOLD INCOME

How much is your total monthly household income? \$ _____

Have you had any change in your household income in the last three months? ☐ Yes ☐ No

If yes, please describe: _____

Have you had any significant increases in household expenses over the last three months? ☐ Yes ☐ No

If yes, please describe: _____

Please list all sources and amounts of monthly income for each adult 18 years or older in the household:

Head of Household Info

First Name: _____

Last Name: _____

Income Source	Amount	Income Source	Amount
Earned/Employment Income		General Assistance	
Unemployment Income		Retirement Income from Social Security	
Supplemental Security Income (SSI)		Child Support	
Social Security Disability Income (SSDI)		Alimony or other spousal support	
Veteran's Disability Payment		Unemployment Insurance	
Private Disability Insurance		Veteran's Pension	
Worker's Compensation		Other (list):	
TANF		Other (list):	

Non Cash Benefits You Receive

Food Stamps	<input type="checkbox"/> Yes <input type="checkbox"/> No	TANF Child Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	TANF Transportation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other TANF-funded Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
State Children's Health Insurance Pgm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Section 8, public housing or other subsidy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: (please list)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Veterans Administration (VA) Medical Services	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you have a Bank Account? ☐ Yes ☐ No Checking \$ _____ Savings \$ _____ Other \$ _____

Do you have any assets (e.g., car, property, CD, IRA, 401K)? ☐ Yes ☐ No

Other Relevant Information on income or assets: _____

Do you have any debts? ☐ Yes ☐ No - List totals

Utilities \$ _____ Credit Card \$ _____ Medical Bills \$ _____ Car \$ _____ Overdue Child Support \$ _____

Rent \$ _____ Mortgage \$ _____ Gambling \$ _____ IRS \$ _____ Other: \$ _____

Do you owe money to DMHA ☐ Yes ☐ No Total owed: \$ _____

Are your wages being garnished? ☐ Yes ☐ No If yes, what amount per month? _____

If you pay child support, monthly amount? _____ Back payment amount? _____

Total Monthly debts \$ _____

Please list all sources and amounts of monthly income for each adult 18 years or older in the household:

Next Adult	First Name:	Last Name
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Income Source	Monthly Amount	Income Source	Amount
Earned/Employment Income		General Assistance	
Unemployment Income		Retirement Income from Social Security	
Supplemental Security Income (SSI)		Child Support	
Social Security Disability Income (SSDI)		Alimony or other spousal support	
Veteran's Disability Payment		Unemployment Insurance	
Private Disability Insurance		Veteran's Pension	
Worker's Compensation		Other (list):	
TANF		Other (list):	

Non Cash Benefits Received

Food Stamps	<input type="checkbox"/> Yes <input type="checkbox"/> No	TANF Child Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	TANF Transportation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other TANF-funded Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
State Children's Health Insurance Pgm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Section 8, public housing or other subsidy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		
WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: (please list)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Veterans Administration (VA) Medical Services	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you have a Bank Account? ☐ Yes ☐ No Checking \$ _____ Savings \$ _____ Other \$ _____

Do you have any assets (e.g., car, property, CD, IRA, 401K)? ☐ Yes ☐ No

Other Relevant Information on income or assets: _____

Do you have any debts? ☐ Yes ☐ No - List totals

Utilities \$ _____ Credit Card \$ _____ Medical Bills \$ _____ Car \$ _____ Overdue Child Support \$ _____

Rent \$ _____ Mortgage \$ _____ Gambling \$ _____ IRS \$ _____ Other: \$ _____

Do you owe money to DMHA ☐ Yes ☐ No Total owed: \$ _____

Are your wages being garnished? ☐ Yes ☐ No If yes, what amount per month? _____

If you pay child support, monthly amount? _____ Back payment amount? _____

Total Monthly debts \$ _____

Repeat above information as needed.

SUPPORTS/INDEPENDENT LIVING

Has anyone been helping you recently? ☐ Yes ☐ No

Name: _____	Relationship _____
Organization/Affiliation: _____	_____
Phone # _____	

If anyone has been helping you, is there anyone you might be able to stay with temporarily? ☐ Yes ☐ No

If yes, Name: _____

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Could you stay with this person while we work to help you find a more permanent place to live? ☐ Yes ☐ No
If yes, can you safely stay there? ☐ Yes ☐ No

What do you think it would take to arrange to stay with this person or family?
Explain: _____

Do you have a case manager at another agency? ☐ Yes ☐ No
If Yes, Name: _____ Agency: _____ Phone: _____

Do you have an open case with Children's Services? ☐ Yes ☐ No
If Yes, Worker Name: _____ Phone: _____

If you are receiving benefits like Social Security or SSI, do you have a representative payee? ☐ Yes ☐ No
If yes, Name: _____ Relationship: _____ Phone number: _____

If you are a member of your household is a Veteran, type of discharge:
☐ Honorable ☐ General ☐ Other than Honorable ☐ Bad Conduct ☐ Dishonorable

Do you have a disabling condition that prevents you from working or functioning well? ☐ Yes ☐ No ☐ Unknown
Please describe: _____

Do you have a physical disability that limits your mobility? ☐ Yes ☐ No ☐ Unknown
Please describe: _____

Are there any restrictions on where you can live? ☐ Yes ☐ No
If yes, please describe: _____

Do you have any legal issues? ☐ Yes ☐ No
If yes, please describe: _____
Are you on ☐ Parole ☐ Probation?
If so, what was the offense? _____

Have you been homeless in the last year? ☐ Yes ☐ No

Is anyone in the household pregnant? ☐ Yes ☐ No
If yes, Name: _____ Due Date: month/year

Do you have Government Issued ID for the head of household? ☐ Yes ☐ No
If Yes, check all that you have: ☐ Driver's License ☐ Birth Certificate ☐ Passport ☐ Green Card
☐ Other Government Issued ID _____

Add "Location" and "Grade" to
"What Schools are your children enrolled in?" Repeat as needed for multiple children
Child's Name: School Name: Location: Grade:

RISK ASSESSMENT (Refer to your agency' protocol for risk assessment)

Are you or anyone in your family on any federal or state sex offender registry? ☐ Yes ☐ No
If yes, describe: narrative text box – up to 2500 characters
Observations of mental state – Intoxicated? Disorganized? Disoriented : _____
Health issues – current distress – bleeding, chest pains, nausea, etc.? ☐ Yes ☐ No
Current Medications? ☐ Yes ☐ No
Do you have medications with you? ☐ Yes ☐ No
Acute suicidal/homicidal/medical issues? (Use agency suicide assessment protocol) ☐ Yes ☐ No
Need for Emergency Services? ☐ Yes ☐ No
Notes/summary

DIVERSION PLAN (if applicable):

Describe: _____

Street Address: _____ City, State, Zip Code: _____

Telephone #: _____

Diversion Type: ☐ Own Apt ☐ With Family ☐ With Friends ☐ Medical Hospitalization ☐ Detox
☐ Psychiatric Hospitalization ☐ Hotel/Motel ☐ Other: _____

Front Door Comprehensive Assessment Domains*

Housing History – Last 5 years

Name/Location	Type	Start	End Date	Leaseholder	Reason for Leaving
	Pick list from Pg 2			Yes or No	Pick list from page 2
<ul style="list-style-type: none"> Ever evicted from DMHA housing? Y or N Restrictions on where can live Y or N with narrative explanation Was the head of household ever in foster care Y or N Barriers to Housing Stability (pick list and then space for "other" with a text box.) Pick list: Trouble budgeting, visitors create problems, involved in illegal activity, no experience as lease holder Housing Plan Who do you plan to have living with you when you leave here? Name : _____ Age _____ Relationship _____ Gender <u>M/F</u> (Allow multiple entries) Housing Goals Motivation to Obtain Housing: High, Medium, Low 					

Employment History – Last 5 Years

Employer	Position/Title	Wage	Start	End	Reason for Leaving
					Pick List
					Better job
					Quit
					Fired
					Laid Off
					Other:
<ul style="list-style-type: none"> Employment Goals Services currently receiving Services Needed to Access or Maintain Employment Motivation to obtain employment: Pick High, Medium or Low 					

Benefits and Entitlements

<ul style="list-style-type: none"> Status – pull from previous income screen and add start and end dates 					
Income Receiving	Start Date/ End Date	Income Source	Start Date/ End Date		
Unemployment Income		General Assistance			
Supplemental Security Income (SSI)		Retirement Income from Social Security			
Social Security Disability Income (SSDI)		Child Support			
Veteran's Disability Payment		Alimony or other spousal support			
Private Disability Insurance		Unemployment Insurance			
Worker's Compensation		Veteran's Pension			
TANF		Other (list):			
<ul style="list-style-type: none"> Plan to apply for or maintain income benefits – text boxes for tasks and separate box for whose responsibility it is. Allow multiple tasks 					
<ul style="list-style-type: none"> Task 			<ul style="list-style-type: none"> Responsible Party 		
Noncash Benefits – Pre-populate from intake assessment	Y or N		Y or N		
Food Stamps	Y or N	TANF Child Care Services	Y or N		
Medicaid	Y or N	TANF Transportation Services	Y or N		
Medicare	Y or N	Other TANF-funded Services	Y or N		
State Children's Health Insurance Pgm	Y or N	WIC	Y or N		
Private Health Insurance	Y or N	Section 8, public housing or other subsidy	Y or N		
VA (Veterans) Medical Services	Y or N	Other: (list)			
<ul style="list-style-type: none"> 					

Front Door Comprehensive Assessment Domains*

- Plan to apply for or maintain noncash benefits – Allow multiple tasks
- Task • Responsible Party
- Barriers to Obtaining/Maintaining Entitlements:

Debts

- Credit Status/Score
- Plan to pay off debts
- Services Needed
- Motivation to resolve credit/debt issues: Pick High, Medium or Low
- Goals

Legal

- Legal Resident Y or N
- Probation/Parole Status to pre-populate from Intake Assessment
- Name of PO: _____ Date Supervision Ends _____

Felony history for last 5 years:

Date	Charge/Crime	Conviction: Pick Yes or No

Incarceration history for last 10 years:

Start Date	End Date	Facility	Reason/Charge

Brief narrative summary of involvement in the legal system: (Maximum 2500 characters)

- Current involvement – e.g., engaging in criminal activity, current legal proceedings, outstanding warrants, subject to order of protection, etc.
- Child support enforcement status
- Goals
- Services Needed
- Motivation to resolve legal issues: Pick High, Medium or Low

Education History

Highest Grade Completed: ☐ Some HS Last Grade completed : _____ ☐ HS Diploma or GED
☐ Some College ☐ Associate's Degree ☐ Bachelor Degree ☐ Technical Certification - Field: _____
☐ Other _____

- Current status
 - ☐ In school Name of School: _____
 - ☐ Applying Expected date of Enrollment: month/year
- Education Goals
- Services Requested

Physical and Behavioral Health

- Where do you usually go for healthcare or when you're not feeling well? [pick specific hospital or clinic]
 - ☐ Community Health Centers of Greater Dayton
 - ☐ Charles Drew
 - ☐ Corwin Nixon
 - ☐ East Dayton
 - ☐ Miami Valley Hospital
 - ☐ Grandview Hospital
 - ☐ Good Samaritan Hospital
 - ☐ Samaritan Clinic/Health Care for the Homeless Clinic
 - ☐ Private doctor
 - ☐ VA
 - ☐ Other: (name): _____

Front Door Comprehensive Assessment Domains*

- Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?:
 - a. Kidney disease/ End Stage Renal Disease or Dialysis: Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - b. History of frostbite, hypothermia or immersion foot: Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - c. Liver disease, Cirrhosis or End-Stage Liver Disease Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - d. Heart disease, Arrhythmia or Irregular heartbeat: Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - e. HIV+/AIDS: Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - f. Emphysema: Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - g. Diabetes: Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - h. Asthma: Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - i. Cancer: Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - j. Hepatitis C Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - k. Tuberculosis Yes ☐ No ☐ Refused ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐
 - l. high blood pressure, hypertension Yes ☐ No ☐ Refuse ☐
 If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
 If yes, have you been hospitalized for this in the past year? Yes ☐ No ☐ Refuse ☐

Programmer – please add this note to Service Point Users. “If the individual answers yes to any of questions a-k above and has been hospitalized for it in the past year, make a referral to the Samaritan Clinic for a medical vulnerability assessment.”

- Have you had a serious brain injury or trauma that required hospitalization or surgery? Yes No Refused
- How many times have you been to the emergency room in the past three months? _____
- How many times have you been hospitalized as an inpatient in the past year? _____
- How many times have you been hospitalized as an inpatient in the past 3 years? _____
- Are you currently or have you ever received treatment for mental health issues? Yes No Refused
- Have you ever been taken to the hospital against your will for mental health reasons? Yes No Refused
- Diagnosis: Medical, Mental Health, Substance Abuse, Mental Retardation, etc - allow for multiple entries - include name, title and date for diagnosis
- Is the diagnosis documented by a qualified individual? Y or N
- Severity of Each Illness – In SP – “Description of Axis I, II, etc” but not severity
- Current Treatment/Service Providers - Name, Organization and Phone Number (multiple entries)
- Previous Treatment Providers – Agency/Hospital, Dates of service – allow multiple entries
- Describe how health issues impact housing stability
☐ paying rent ☐ disruptive behavior ☐ hoarding ☐ noise ☐ visitors
 Other: _____
- Has health insurance ☐ Y or ☐ N
- Current medications list
- Adherence to medication regimen Pick ☐ Almost Always ☐ Sometimes ☐ Never

Front Door Comprehensive Assessment Domains*

- If substance abuse diagnosis, current status and impact on functioning
☐ Actively using and not a problem ☐ Actively using and a problem ☐ Reducing use
☐ Abstinant: Date of Sobriety mm/dd/yy
- Frequency of Use: ☐ Daily ☐ Several Times Per Week ☐ Once a Week ☐ Less than 1X/week
- Types of substances used: pick list – pick all that apply: Cocaine, Prescription Drugs, Crystal Meth, Amphetamines, Heroin, Marijuana, Alcohol Other: list:
- Hospitalizations in last 3-5 years - Dates, Reasons, Hospital Names
- Detox in last 3 years – Number of inpatient detox stays – list of hospitals and clinics but not "detox"
- Services Needed
- Motivation to use services: pick Pre-contemplation, Contemplation, Preparation, Action, or Maintenance . Allow room for narrative explanation

Family/Dependent Children

- Domestic violence history
- School Attendance/Performance of children
- Child custody arrangements currently
- If you have children that are not with you, how many are there?
- Is there a reunification plan? Yes ☐ or No ☐
- Child care arrangements
- Special Needs
- Children's Services Involvement – status, worker name and contact to pre-populate from page 5
- Goals
- Services Needed
- Motivation to use services: Pick High, Medium or Low

Independent Living Skills/ Supports

- Status of ID for all household members
- Nature of social and familial relationships – identify supports and significant others, also identify negative influences and relationships
- History of seeking and using help/assistance
- Goals

Independent Living Skills Checklist

1 - Mostly Independent 2 - Needs Help Sometimes 3 - Needs Help Most of the Time 4 - Always Needs Assistance

1. Paying bills	1-4
2. Budgeting	1-4
3. Maintaining entitlements and other paper work	1-4
4. Maintaining a home	1-4
5. Preparing/Obtaining meals	1-4
6. Travelling	1-4
7. Personal Care/hygiene	1-4
8. English Proficiency	1-4
9. Awareness of needs and knowing when to seek help	1-4
10. Able to access help when needed	1-4
11. Managing health/behavioral health needs and services, etc	1-4
12. Taking medications	1-4
13. Keeping Appointments	1-4
14. Discriminating danger/asserting and protecting self	1-4

Total Score on Independent Living Skills (Range 14-56)

- Ability and motivation to improve skills: Pick High, Medium or Low

Front Door Housing Barriers Screen

This form aims to capture some common housing stability barriers facing homeless people and those at risk of homelessness. Much of the information can be found in the intake form. The rest can be gathered directly from the participant. Some information may be unknown or people may refuse to answer. This is to be expected, although it would be preferable to have as much information as possible. The housing barriers screen should be used to develop Housing Plans for each household and for re-assessments for those that receive ongoing assistance. **CHECK ALL THAT APPLY.**

Income <input type="checkbox"/> No income <input type="checkbox"/> Has income but it's below 30% of AMI <input type="checkbox"/> Recent decrease in income <input type="checkbox"/> Receiving unemployment or other income that is time-limited <input type="checkbox"/> Sanctioned or timed out on TANF <input type="checkbox"/> Paying more than 50% of income for rent <div style="text-align: right;">Score _____ of 6</div>	Debts/Expenses <input type="checkbox"/> Recent increase in monthly expenses <input type="checkbox"/> Monthly obligations exceed monthly income <input type="checkbox"/> Poor credit history <input type="checkbox"/> Currently in bankruptcy <input type="checkbox"/> Debts to the utility company <div style="text-align: right;">Score _____ of 5</div>
Employment <input type="checkbox"/> No High School Diploma or GED <input type="checkbox"/> Unemployed <input type="checkbox"/> Currently in temporary or seasonal job <input type="checkbox"/> Inconsistent work history – gaps in employment or frequent changes in jobs <input type="checkbox"/> Lacks adequate transportation <div style="text-align: right;">Score _____ of 5</div>	Legal Issues <input type="checkbox"/> Change "Child Support Enforcement" to "Subject to Child Support Enforcement – e.g., garnish wages" <input type="checkbox"/> On parole <input type="checkbox"/> On probation <input type="checkbox"/> History of incarceration <input type="checkbox"/> Felony within last 5 years <input type="checkbox"/> Restrictions on housing location – e.g., sex offender, DV <input type="checkbox"/> Undocumented immigrant <div style="text-align: right;">Score _____ of 7</div>
Housing History <input type="checkbox"/> Homeless in the last 12 months Add this instruction: (✓ if currently homeless) <input type="checkbox"/> Multiple episodes of homelessness <input type="checkbox"/> Chronically homeless or on long stayer list <input type="checkbox"/> One or two legal evictions <input type="checkbox"/> More than 2 evictions <input type="checkbox"/> Never had own lease <input type="checkbox"/> Lack of rental history of more than 1 year <input type="checkbox"/> Barred from public housing for eviction or other threshold status (crystal meth, etc.) <input type="checkbox"/> Evicted from other subsidized housing <input type="checkbox"/> History of institutional care – e.g., state hospital, foster care, prison <div style="text-align: right;">Score _____ of 10</div>	Family Status <input type="checkbox"/> Custody of 3 children <input type="checkbox"/> Custody of 4 or more children <input type="checkbox"/> 1 or more custodial children < age of 5 <input type="checkbox"/> Single adult under age 22 <input type="checkbox"/> Head of household under 25 years old with children or pregnant <input type="checkbox"/> Current or past involvement with foster care system <input type="checkbox"/> Unmet child care needs <input type="checkbox"/> Domestic violence survivor <input type="checkbox"/> Has child with special needs <input type="checkbox"/> Children not attending school regularly <div style="text-align: right;">Score _____ of 10</div>
Health/Disability <input type="checkbox"/> Chronic physical illness <input type="checkbox"/> Health crisis, detox or hospitalization in the past year <input type="checkbox"/> Ongoing medical needs and no health insurance <input type="checkbox"/> One disabling condition such as mental illness, SA <input type="checkbox"/> Multiple disabling conditions <input type="checkbox"/> Disabling condition has negatively affected housing stability <input type="checkbox"/> Change "Not in treatment for ongoing health issue(s) to "Not in treatment for ongoing, health, <u>MH</u> or <u>SA</u> issues" <div style="text-align: right;">Score _____ of 7</div>	Supports/Independent Living Skills <input type="checkbox"/> No or limited support networks <input type="checkbox"/> History of being unable or unwilling to seek help <input type="checkbox"/> Engaged in abusive relationship <input type="checkbox"/> Limited English proficiency <input type="checkbox"/> Never had driver's license <input type="checkbox"/> Hoards to point of a health or safety risk <input type="checkbox"/> History of problem visitors in past housing <input type="checkbox"/> No Government Issued ID for any household member <input type="checkbox"/> Does not have 2 landlord references <div style="text-align: right;">Score _____ of 9</div>
Subtotal _____ of	Subtotal _____ of
Total _____ of 59 Level of Need: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	

Homeless Solutions Policy Board
Referral Decision Worksheet

Step 1: Identify Assessment Filters

Assessment Filters

Income (check one)

- ☐ Regular income or recent work history
- ☐ Some income
- ☐ No income

Independent Living Skills (check one)

- ☐ ILS < 35
- ☐ ILS ≥ 35

Housing Barriers Score (check one)

- ☐ Low: Singles < 14, Families < 14, Youth, < 13
- ☐ Medium: Singles 14-19, Families 14-21, Youth 13-18
- ☐ High: Singles 20+, Families 22+, Youth 19+

Disability Status (check one)

- ☐ Documented disability and needs long term supports
- ☐ SMD but not engaged in treatment
- ☐ SA with treatment interest
but not connected to mainstream treatment

Recovery Status (check one)

- ☐ Precontemplation
- ☐ Contemplation
- ☐ Preparation
- ☐ Action
- ☐ Maintenance

Life Transition Issues (check if applicable)

- ☐ Interest in SA Treatment, pregnant, young adult 18-21,
fleeing DV
- ☐ Indicate transition issue:

Placement Considerations (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Convicted Sex Offender | <input type="checkbox"/> Handicap accessible unit required |
| <input type="checkbox"/> Veteran | <input type="checkbox"/> School/neighborhood preference |
| <input type="checkbox"/> Large family needs at least 3-bedroom unit | <input type="checkbox"/> Other _____ |

Homeless Solutions Policy Board
Referral Decision Worksheet

Step 2: Apply Rapid Rehousing Filter

First determine if the person can be served in Rapid Rehousing. If so, go to step 4.

☐ Rapid Rehousing

Program Criteria

☐ Regular income or recent work history
(Can be used as a bridge to permanent subsidy)

Step 3: If not referring to RR, select another referral option based on the best match with the household's characteristics and your knowledge of their need for services. Applicants must meet all program criteria for the option selected.

☐ Permanent Housing

Referral Criteria

- Low or Medium on barriers
- May need SSO if going to PH from ES or TH and have substance abuse diagnosis and is not connected to mainstream treatment

☐ Programmatic Shelter

- No income or inadequate income
- ILS score < 35
- At least medium on housing barriers
- If **individual** with substance abuse problem, client expresses interest in treatment
- If **family**, no behavioral health issues beyond substance abuse
- If **youth**, 18 or younger

☐ Transitional Housing
(Facility Based)

- No income or inadequate income
- ILS score \geq 35
- Early recovery, pregnant, transitioning from DV, youth
- At least medium on housing barriers
- If **youth**, 18 - 21 years of age

☐ Transitional Housing
(Scattered Site)

- No income or inadequate income
- ILS score \geq 35
- Early recovery, pregnant, transitioning from DV, youth
- At least medium on housing barriers, **individuals** and **families**
- Low to medium on housing barriers, **youth**
- If **youth**, 18 - 21 years of age

☐ Permanent Supportive Housing

- No income or inadequate income
- ILS score \geq 35
- Documented disability that impedes ability to live independently
- At least medium on housing barriers

☐ Safe Haven

- Severe mental illness
- Not engaged in mental health treatment
- ILS score \geq 35
- At least medium on housing barriers

☐ Supportive Services

- If going to PH, has behavioral health diagnosis and is not connected to mainstream treatment

Homeless Solutions Policy Board
Referral Decision Worksheet

Step 4: Document Referral Decision

Referral Decision - INITIAL Result

- ☐ Rapid Rehousing
- ☐ Permanent Housing
- ☐ Gateway/Emergency Shelter
- ☐ Programmatic Shelter
- ☐ Transitional Housing (TH-Scattered)
- ☐ Transitional Housing (TH-Facility)
- ☐ Permanent Supportive Housing (PSH)
- ☐ Safe Haven (SH)
- ☐ Supportive Services (SSO)
- ☐ Street Outreach

Program Name in ServicePoint:

Housing Expense Assistance BH-3800
Market Rate Housing BH-7000.5100
Crisis Shelter BH-1800.1500
Homeless Shelter BH-1800.8500
Transitional Housing BH-8600
Transitional Housing BH-8600
Supportive Housing BH-8400
Homeless Drop In Center BH-1800.3500
Housing Counseling BH-3700
Street Outreach PH-8000

Bed/Unit Type Required

- ☐ Studio
- ☐ 1-bedroom
- ☐ 2-bedroom
- ☐ 3-bedroom or larger

Moving On Assessment

- ☐ Yes
- ☐ No

Client Refused Referral (add explanation in Notes section)

- ☐ Yes
- ☐ No

Date of Initial Referral _____

Placement Notes (e.g. unit type, neighborhood preferences, etc.)

Referral Decision - FINAL Destination

- ☐ Rapid Rehousing
- ☐ Permanent Housing
- ☐ Gateway/Emergency Shelter
- ☐ Programmatic Shelter
- ☐ Transitional Housing (TH-Scattered)
- ☐ Transitional Housing (TH-Facility)
- ☐ Permanent Supportive Housing (PSH)
- ☐ Safe Haven (SH)
- ☐ Supportive Services (SSO)
- ☐ Street Outreach

Program Name in ServicePoint:

Housing Expense Assistance BH-3800
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Homeless Shelter BH-1800.8500
Transitional Housing BH-8600
Transitional Housing BH-8600
Supportive Housing BH-8400
Homeless Drop In Center BH-1800.3500
Housing Counseling BH-3700
Street Outreach PH-8000

Date of Final Referral _____

Placement Notes (e.g. unit type, neighborhood preferences, etc.)